State of Montana prescription drug claim audit for the period July 1, 1997 through June 30, 1998

STATE OF MONTANA

PRESCRIPTION DRUG CLAIM AUDIT

FOR THE PERIOD

JULY 1, 1997 THROUGH JUNE 30, 1998

ADMINISTERED BY

EXPRESS SCRIPTS

FINAL REPORT

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.

NOVEMBER, 1998

LEGISLATIVE AUDIT DIVISION

Scott A. Seacat, Legislative Auditor
John W. Northey, Legal Counsel
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Jim Pellegrini, Performance Audit
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December 1998

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the special purpose audit of Express Scripts` administration of pharmacy claims for the Montana Employee Benefit Plan administered by the Department of Administration, and the Montana University System Benefit Plan administered by the Office of the Commissioner of Higher Education for the period starting July 1, 1997, and ending June 30, 1998.

The audit was conducted by Wolcott & Associates, Inc., under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the views of the Legislative Auditor.

The agency's and university's written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

98C-07B

Room 135, State Capitol Building, PO Box 201705 Helena MT 59620-1705

STATE OF MONTANA
PRESCRIPTION DRUG PLAN AUDIT
OF EXPRESS SCRIPTS
JULY 1, 1997 - JUNE 30, 1998

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I- INTRODUCTION

The State of Montana (State) provides a prescription drug benefit as part of an overall employee benefit and compensation program. The plan covers approximately 13,500 employees and retirees, plus their dependents.

The State is a member of the Montana Association of Health Care Purchasers. The Association has negotiated a contract with Express Scripts, Inc.(ESI) to provide prescription drug benefits to employees Association members that elect to provide such benefits. The State has elected to have its prescription drug benefits provided by Express Scripts, Inc.

The Montana Power Company (MPC) and First Interstate Bank (FIB), both members of the Association, have also contracted to have their prescription drug benefits provided by ESI. The Montana University System (MUS), has contracted directly with ESI for the provision of prescription drug benefits.

The State invited the other three plan sponsors to participate in an audit of ESI's processing of prescription drug claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. The Division issued a bid request on June 1, 1998, for the performance of this audit. Wolcott & Associates, Inc. was awarded the audit contract.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and the other three plan sponsors recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. All four sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Division advised Wolcott & Associates, Inc. that we had been awarded the audit contract. All preliminary work was completed and the entrance meeting was held in Helena on August 4, 1998. On-site work at the State, MPC, MUS, FIB and Blue Cross and Blue Shield of Montana (BCBSMT), the organization that manages eligibility and other plan services for two of the plan sponsors, was performed during the week of August 3, 1998.

We had initially scheduled the field work at ESI's Tempe location for the week of August 10, 1998. However, an objection by ESI to our use of an outside vendor for the sorting of electronic claim data, plus other ESI delays, caused us to postpone our on-site work in Tempe until the week of September 7, 1998.

On-site audit services were performed at:

State of Montana
State Personnel Division
Mitchell Building
Helena, Montana 59620

Montana University System
2500 Broadway
Helena, Montana 59620

The Montana Power Company
40 East Broadway
Butte, Montana 59701

First Interstate Bank of Billings, N.A.
401 North 31st Street
Billings, Montana 59116-0918

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Express Scripts, Inc.
1700 North Desert Drive
Tempe, Arizona 85281

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Ray Wolcott, Jr.	President, Project Manager	Yes
Brian Wyman	Manager	Yes
Marie Richman	Senior Auditor	No
Richard Reese	Actuary	No
Sue Weydert	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered prescription drug benefit claims paid by ESI during the period from July 1, 1997 through June, 30 1998. Test work was performed on 311 previously processed claims, all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Confirmation of receipt of prescription.
- Administration of coordination of benefits and subrogation provisions.
- Calculation accuracy.
- Completeness of necessary information.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

Test Claims

Test claims were prepared and entered into the system to test various aspects of the system's capabilities. The test claims addressed the following:

- Claims for terminated individuals.
- Claims from a fictitious provider.
- Claims that had been paid primary by another benefit plan for an individual with no documented COB data.
- Claims for drug prices in excess of the contract price.
- Claims for medication inconsistent with the patient's sex.
- Claims filed once by the pharmacist and then by the participant.

LIST OF ADMINISTRATIVE OFFICIALS

Listings of administrative officials for both the Department of Administration and ESI are presented below.

Department of Administration administrative officials at the time of our audit, included:

Director, Department of Administration - Lois Menzies
Administrator, State Personnel Division - John McEwen
Chief Employee Benefits Bureau - Joyce Brown
Operations Supervisor - Sheri Parsons

ESI administrative officials at the time of our audit, included:

VP Site Operations - Tempe - Mabel Chan
Director Client Services - LeAnn Dale
Account Manager - Lisa Frey
Director Internal Audit - Doug Menendez

II -STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with 90% confidence and a precision of + or -3%, assuming an error rate of 3%. The sample size required to meet these requirements is 88.

Wolcott & Associates, Inc. prefers to express its results with 95% confidence. Holding all other requirements constant, that would have required a sample size of 129 claims. Following discussions with the State regarding deductible and co-pay errors, we concluded that the frequency of error might exceed 3%. As a result, we proposed to audit a sample of 211 claims. This is a sample large enough to be 95% confident with a precision of + or - 3%, if the error rate equals 5%.

When ESI acted to delay our scheduled field audit by a month, we chose to increase the sample size by 100 claims, including 50 adjustment claims.

The claims were selected from the population of claims paid by ESI between July 1, 1997 and June 30, 1998. Prior to selection, the population of claims was stratified. Information regarding the population strata and the sample strata are presented below.

STRATIFIED POPULATION AND SAMPLE DATA

		Population		Sample	
Strata	**Description**	**Number**	**Total Dollars**	**Number**	**Total Dollars**
1	Payments Exceeding $2,292.52	31	$ 88,137.41	31	$ 88,137.41
2	Payments Between $173.96 and $2,292.52	10,834	$3,354,301.54	45	$ 14,974.38
3	Payments Between $77.61 and $173.96	30,201	$3,354,177.35	45	$ 5,045.49
4.	Payments Between $39.14 and $77.61	63,121	$3,354,212.26	45	$ 2,410.30

5.	Payments Between $0.01 and 39.14	277,494	$3,354,209.66	45	$ 563.39
6.	Zero Payment Claims	33,629	$ 0.00	50	$ 0.00
	Total	415,310	$13,505,038.22	261	$111,130.97

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on each plan's provisions in force as of the date the prescription was dispensed. Ingredient costs were calculated based on Average Wholesale Prices or other applicable prices in effect on the date the prescription was dispensed.

The percentage discounts, dispensing fees, administration fees, deductible and copayment amounts were compared to each plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan requirements for:

- Exclusions,
- Appropriate copayment (generic, branded, etc.)
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations and
- Maintenance versus acute care.

DEFINITION OF ERROR

All paper filed claims were paid to the participant. All network pharmacy (electronic claims) were paid to the pharmacist.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

AUDIT RESULTS

Of the 261 claims in our statistical sample (excluding adjustments which are discussed below) 8 were judged to contain a payment error. This represents a frequency of payment error of 3.1%. Of these 8 claims, 6 were overpayments and 2 were underpayments.

Our sample contained a total payment of $111,130.97 for the 261 claims. The overpayments

totaled $127.28 or 0.11% of the total. The underpayments totaled $270.32 or 0.24% of the total.

The frequency of payment error in our sample exceeded the frequency of errors typically found by Wolcott & Associates, Inc. during similar audits. Based on our experience, the frequency of payment error in card driven prescription drug programs typically does not exceed 1.0% and the magnitude of payment error seldom exceeds 0.5%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of +or - 3.0%, that the true frequency of error in the population is 2.4%.

Based on this extension, we are 95% confident with a precision of + or - 0.5%, that the true magnitude of payment error in the population is $96,982. The magnitude of payment error is the sum of $93,993 in projected overpayments plus $2,989 in projected underpayments.

ADJUSTMENT ENTRIES

We reviewed 50 adjustments made by ESI during the audit period. The purpose of this review was to: (1) determine that adjustments were being processed properly and (2) identify the reasons for adjustments.

Based on the results of our review, we conclude:

- ESI appears to have properly processed adjustments based on their internal procedures.
- Pharmacies do not inform ESI regarding the reasons for adjustments.
- We were advised by ESI's Account Manager in Tempe that adjustments made more than seven days after the original transaction are charged the per claim administration fee regardless of the reason for the adjustment.

The lack of data regarding the reasons for adjustments precluded an analysis of the reasons for the adjustments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

The most common error type involved the incorrect calculation of copay for State Claims. This error type occurred three times. Two of the errors occurred because the software cannot accurately calculate the out-of-pocket limit. One additional error occurred when a State claim was processed using a 25% copay. We have been unable to locate any documentation for a 25% copay.

Two errors occurred as a result of the calculation of AWP on the date the bill was received rather than on the date the prescription was dispensed. Both claims were Buttrey mail order claims. The documents all refer to the use of current AWP information. Both network and paper claims are processed based on AWP as of the date the prescription is filled. Payment of mail order claims using AWP as of the date ESI receives the bill is not provided for in the Agreement and is inconsistent.

One error occurred when the claim was processed using the copay amount in effect for the prior plan year.

Another error occurred when 112 birth control pills were dispensed. ESI could not confirm that the prescription had received prior approval and there is no indication that the DUR edits identified the excessive number of pills.

Finally, a paper claim was processed based on billed charges rather than AWP less the discount.

A summary of error by type is presented below:

EXPRESS SCRIPTS PHARMACY CLAIMS
JULY 1, 1997 THROUGH JUNE 30, 1998
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
AWP less discount lower than billed ingredient cost.	2	13.85
Copayment and/or deductible exceeded out-of-pocket limit.	2	-270.32
Copay charged is lower than stated in plan.	1	5.00

112 birth control pills dispensed as 88 day supply. DUR did not identify.	1	82.47
Brand name copay is 30%. Copay of 25% charged.	1	1.70
Paper claim paid based on submitted cost instead of network cost.	1	24.26
Total	8	$ -143.04

III - PARTICIPANT CONFIRMATIONS

Our work plan included the preparation and mailing of 125 confirmations to participants who had received prescriptions under the plan. The results are discussed below.

A separate sample of claims processed during May and June 1998 was selected for confirmation purposes. While it was possible that the sample would include both electronic and paper filed claims, no paper filed claims were identified in the confirmation sample.

The address for each claimant was obtained from the plan sponsor. A letter, requesting confirmation of the prescription, was mailed to each.

We received 76 responses to our initial confirmation request. A second mailing was made and attempts were made to contact those who did not respond by telephone. We also requested the assistance of the plan sponsors in contacting 16 of the participants.

All but 10 of the 125 participants eventually responded.

Of those that responded, all but 3 confirmed that the prescription was received and that the copay agreed with the records at ESI. Each of the 3 that did not agree with ESI records are discussed below.

- One participant reported that her records did not show that she had received the prescription. We obtained a copy of the receipt she signed at the pharmacy and mailed it to her. Subsequently, she confirmed that the signature was hers and that she did receive the prescription.

- One participant reported that she had ordered the prescription, but did not pick it up. We contacted ESI and confirmed that the transaction had been reversed.

- One participant reported that she paid a copayment amount greater than the amount shown on the ESI system. We contacted the pharmacy and obtained a copy of the receipt showing an amount that agreed with the ESI report. This was sent to the participant, who then agreed that the copay was correct.

We have no reason to believe there were irregularities regarding the services provided to the individuals we were unable to contact.

Based on the results of our confirmation activity, we conclude that prescriptions reported on the ESI system are actually being dispensed.

No exceptions were noted.

IV - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to ESI. This section describes the methods employed and presents the results of the verification of eligibility for the 306 of the claims in our sample where a payment was made by ESI. (We confirmed eligibility once for a participant if more than one claim for the family was included in our sample.)

STATE OF MONTANA

The State prepares and sends to ESI a monthly eligibility tape showing each individual to be covered for the coming month. ESI runs this tape and compares it to the data for the prior month. A reconciliation report is produced by ESI showing each person whose coverage is to terminate as of the last day of the month prior to the date for which the new eligibility data applies.

ESI sends the reconciliation report to the State and requests confirmation that everyone on the list should be terminated.

Each month the State confirms that, yes indeed, those people should have their coverage terminated at the end of the month.

Problem

We were advised by the State that ESI receives the confirmed reconciliation report and then terminates the coverage for those individuals. However, the termination is effective as of the moment the system is updated rather than as of the end of the month.

This has caused the State to be very careful in the timing of the return of the reconciliation report so that the transaction is performed in the system by ESI as close to the last day of the month as possible. If the system updates too early in the month, participants will not be able to use the coverage through the end of the month. If the system updates after the end of the month, participants may use their card after their coverage has expired.

We were asked to discuss possible solutions to this problem with ESI.

Solution

ESI has two methods that clients may use to access the eligibility system. One method permits the client to make direct and immediate changes to the system. The other, used by the State, results in the generation of a reconciliation report.

ESI suggested that the State (1) notify ESI in writing that they want all reconciliations to be updated as of the end of the month and (2) make the same request each month as the report is returned. This should result in having all such transactions occur as of the end of the month.

ESI's Internal Audit Department has suggested that the State provide actual termination dates as a solution to the problem.

Eligibility Verification

Each of the 186 State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the prescription was dispensed.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

BCBSMT processes claims for the MUS health care plan. BCBSMT has also contracted to provide eligibility data to ESI on behalf of MUS. BCBSMT receives the enrollment data from each campus on a daily basis and transmits new entrant, change and termination data to ESI electronically each day.

The transmission is not directly to the ESI system. ESI updates the system based on data from BCBSMT. However, we were advised by BCBSMT that a delay of 72 hours is typical.

Eligibility Verification

Each of the 64 MUS participants in our sample was researched on the BCBSMT eligibility system. Sixty-three agreed with the BCBSMT records as being covered at the time the prescription was dispensed.

For one individual, the sex and date of birth, as reported by ESI, did not agree with the BCBSMT data. The family member was reported as a child. BCBSMT records show she is the spouse.

We believe that both the child and the mother were covered when a prescription for one of them was dispensed.

No other exceptions were noted.

THE MONTANA POWER COMPANY

MPC has also engaged BCBSMT to process and transmit eligibility data to ESI. The process is similar to that performed at MUS and BCBSMT performs similar services.

Eligibility Verification

We researched MPC's employment records for each of the 49 selected claimants. MPC's records confirmed that 48 participants were covered as of the date the prescription was dispensed.

One individual's coverage had terminated prior to the date a prescription was dispensed. ESI's records show that they were never notified of the termination. We have discussed the situation with MPC and with the Account Manager in Tempe.

No other exceptions were noted.

FIRST INTERSTATE BANK

FIB has direct, on-line access to the ESI system for purposes of updating participant eligibility. FIB processes all eligibility transactions, as they occur, directly into the ESI system.

Eligibility Verification

We researched the FIB employment records for each of the seven selected claimants. FIB records confirm that all seven were covered on the date the selected prescription was dispensed.

No exceptions were noted.

V - CLAIM PAYMENT AND ESI REIMBURSEMENT

The scope of our service included the measurement of two time periods: (1) the time required by ESI to process claims and reimburse pharmacies and participants and (2) the time required by the plan sponsors to reimburse ESI. The results of our test work for both measures are presented below.

CLAIM PAYMENT TIME

ESI processes most claims electronically. Under this method, the patient presents an identification card containing information, including the participant's Social Security number, plan sponsor's name and the plan's copayment and deductible provisions.

The pharmacist fills the prescription and enters the required data into the ESI system using the pharmacy's computer. The system calculates the copay amount, amount to be charged to the plan sponsor and the amount to be paid to the pharmacy.

Pharmacies are then reimbursed on a cycle specified in their contract with ESI.

Participants who elect to use non-ESI member pharmacies, participants who have not yet received an ESI card and State participants whose ESI coverage is subject to the COB provision, must file their claims directly with ESI.

These claims are manually processed by ESI and checks are prepared and mailed to the participant.

We measured the time required to pay pharmacists as the elapsed calendar days between the date the prescription was dispensed and the date ESI issued the check.

Our results are presented below. The results are for 204 claims. No elapsed time was measured for the following:

- Adjusting entries and
- Claims with no payment.
- Participant filed paper claims

Paper Claims

Our sample included seven paper claims that had been filed by participants. Six of these were State employees, one was a MUS employee. ESI's procedure is to hand write the received data on each claim without the use of a date stamp or any further notation as to what the date signifies. A handwritten date was noted on one claim. However, the lack of readable data on other claims precluded our calculation of turnaround time for the paper claims.

Overall Results

Overall results from the measurement of the time required by ESI to pay pharmacists shows the following as measured from the date the prescription is dispensed to the date ESI issues the payment to the pharmacy.

Measure	Elapsed Days
Mean	25.6
Median	23
Mode	22

Information for each of the four plan sponsors is presented as Exhibit B.

REIMBURSEMENT PROCESSING TIME

ESI submits invoices for reimbursement for prescriptions dispensed and their administrative fees. The frequency of the invoices and the payment terms differ for each plan sponsor and the various plan years covered by our audit. Presented below is information regarding the contractual provision and the actual time required to reimburse ESI based on records made available to us.

State of Montana

Prior to January 1, 1998, the State's agreement with ESI called for ESI to receive the State's check reimbursing ESI for prescription costs and fees within 15 business days of the date of ESI's invoice. As of January 1, 1998, the agreement required a bank wire transfer within 48 hours of the receipt of the invoice.

We gathered invoices from July 1, 1997 through June 30, 1998 and measured the elapsed time between the invoice date and the date payment was made by the State. To adjust for mail time, we allowed 3 days. Measurement was therefore based on 18 calendar days (3 weeks less 3 days).

A total of 81 invoices were included in our review. These included invoices for manual claims as well as electronic claims. Of these, 12 invoices required more than 18 days to pay, measuring from the invoice date to the payment date.

Forty-nine of the invoices were received after January 1, 1998. None of these invoices were paid in less than 8 days. We were unable to identify a received date stamp on any of the invoices. However, allowing 3 days for mail delivery, none of the invoices were paid within 48 hours of receipt.

All invoices dated prior to August 31, 1997, contained payment terms of "Net 30 Days". All invoices dated on and after August 31, 1997, contained payment terms of "Net 15 Days". These

payment terms do not agree to those specified in the agreements.

Of the twelve invoices dated prior to August 31, 1997, all but one was paid within 30 days of the invoice date. Of the 69 invoices dated after August 30, 1997, all but 10 were paid within 15 days of the invoice date.

Montana University System

The agreement we were provided by MUS did not include the **Exhibit** that described the payment terms. However, all reimbursement by MUS during the audit period were made by bank wire transfer either on the date the invoice was received or the following day. As a result, we conclude that MUS has complied with the ESI reimbursement requirements even if they required wire transfer within 48 hours of receipt of the invoice.

Three of the invoices from ESI contained "Net 30 Day" payment terms. The balance of the invoices contained "Net 7 Day" payment terms.

Invoice MN00774001 and invoice MN00773001 were both dated October 13, 1997. they were both invoices for $11.50 for one manually processed claim (paper claim). The invoices were for duplicate payments of the same prescription. Both invoices were paid by MUS. We discussed this matter with ESI, however, we have received no confirmation that the overpayment has been refunded.

MUS recorded the received date for all invoices. We measure the elapsed time from the invoice date to the received date recorded by MUS. Delays of over a week were not uncommon. One invoice was recorded as received 34 days after the date of the invoice. If these delays are representative of the delays experienced by the State, it is reasonable to conclude that the delays in invoice payment recorded are not entirely the result of delays at the State.

The Montana Power Company

The ESI agreement describing reimbursement is contained in an agreement between ESI and BCBSMT. The agreement calls for reimbursement within 15 business days of the date of the invoice. As with the 1997 invoices to the State, we measured based on 18 calendar days to adjust for the mail time from Helena to Tempe.

ESI sends BCBSMT two invoices per month for MPC. Of the 24 invoices reviewed, 4 required more than 18 days to pay.

Each of the 24 invoices contained a "Net 30 Day" payment term. All 24 invoices were paid within 30 days of the invoice date.

BCBSMT does date stamp the invoices when received. However, we were only able to read

the received dates on 4 of the copies provided to us. The elapsed time between the invoice date and the received date stamped by BCBSMT ranged from seven to ten days.

First Interstate Bank

The FIB agreement provided to us states that FIB will reimburse ESI by bank wire transfer within 48 hours of receipt of the invoice. Invoices were received twice each month through November 1997, and then monthly through the end of the audit period. We reviewed 15 invoices. None of the invoices contained received date stamps indicating when they were received by FIB. The elapsed time between the invoice date and the payment date ranged from six days to 54 days. All but two invoices were paid with 14 days of the invoice date.

Four of the invoices contained "Net 30 Days" payment terms. The balance of the invoices contained "Net 15 Days" payment terms. Only two invoices required more than 15 days (from the invoice date) to pay.

Comment

The contractual reimbursement terms and the payment terms on each invoice are in conflict.

Received date information, while not extensive, suggests that ESI does not mail invoices promptly.

ESI has repeatedly accepted reimbursements after the date specified in the agreements for these four plan sponsors without imposing a late payment penalty. We believe such action has effectively waived any penalties and ESI would be estopped from prospectively or retroactively imposing such penalties for the duration of their agreements with the four plan sponsors.

VI - EXPRESS SCRIPTS COMPLIANCE

This section discusses the results of our review of the compliance with State regulations and contract provisions.

STATE REGULATIONS

Sections 37.7.101 through 37.7.712, MCA address the regulation of pharmacies. Section 37.7.701 through 37.7.712 present regulation for Out-Of-State Mail Service Pharmacies.

The four plan sponsors whose plans are the subject of this report have elected to utilize a Montana domiciled mail service pharmacy. ESI operates an Out-Of-State Mail Service Pharmacy, however, this service is not being used by the four plan sponsors.

We are unaware of any other State regulations applicable to the provision of pharmacy benefit services. We conclude, based on our review, that ESI is in compliance with State regulations.

CONTRACT PROVISIONS

ESI has entered into contracts with the Association and each plan sponsor. Information regarding our review of these contracts is presented below.

ASSOCIATION AGREEMENT

The contract between the Association and ESI was renewed as of January 1, 1998. The contract specifies the services to be provided by ESI. This agreement relates to the plans sponsored by the State, MPC and FIB. These services include:

- Accurate processing of claims based on plan provisions and agreed upon pricing.
- Audits of participating pharmacies.
- Drug Utilization Review services.
- Preparation of reports.
- Performance of prior authorization services.
- Performance and cost savings guarantees.
- Coordination of benefits claim processing.

The results of our review of these activities are presented below.

Accurate Processing of Claims

Prescription drug claim processors typically encounter delays between the effective date of a change in the Average Wholesale Price (AWP) of a drug and the date that the information is loaded into the claim processing system. We accept the fact that delays will occur. To the extent that drug prices tend to increase mor than decrease, the delay does not tend to increase the cost of prescription drugs for the participants or the plan sponsors.

However, we do find it worth noting that pharmacies tend to utilize the new AWP information more rapidly than those who process such claims.

Based on the results of our audit of previously processed claims, we conclude:

- The ESI system is not capable of limiting a participant's out-of-pocket expense to the dollar limit specified in the Plan document. The most common situation may involve claims where both a deductible and copy are charged to a prescription.

- ESI personnel responsible for updating the claim processing software based on changes to plan provisions appear to be inconsistent in making such changes effective as of the benefit plan change date. Such delays have resulted in overpayments due to the use of incorrect copay amounts.

- The ESI system appears to have difficulty processing COB claims. Processors were instructed to suspend payment of COB claims as of August 10, 1998. We are unaware that the system has been corrected.

Other comments regarding the accuracy of claim payments are presented in Section II.

Audit of Participating Pharmacies

ESI has the right to audit participating pharmacies. ESI agrees to pay the plan sponsors 80% of all overpayments recovered during such audits.

ESI provided no documentation regarding the conduct of such audits in the State of Montana, nor were we able to confirm that the four plan sponsors were ever paid for recovered amounts.

Drug Utilization Review

ESI has agreed to conduct DUR services. These services include a review of:

- Drug-to-drug interactions,

- Drug allergy interactions,
- Drug-to-age interactions,
- Drug-to-medical condition interactions,
- Duplicate prescription,
- Exceeding maximum dosage,
- Refill too soon,
- Drug dosage, and
- Therapeutic duplications.

Without detailed medical information, ESI cannot review medical condition interactions or allergy interactions. We noted numerous incorrect patient age and sex entries on the claim reports. This lack of accurate data interferes with ESI's ability to check age or sex interactions. ESI's Internal Audit Department has requested our documentation. It has been provided.

We noted several situations where participants had received therapeutic duplications (involving multiple strengths and multiple brand names). We were not provided evidence that the DUR service had identified these situations.

The system does appear to be adequate to identify duplicate claims. However, the paper claim system did permit the payment of a duplicate claim for MUS. We have supplied the documentation to ESI both in St. Louis and Tempe.

We reviewed the claim history for one participant who received a 30 day supply of a contraceptive plus a 90 day supply of the same contraceptive in the same week. The services were provided by the same pharmacy and used the same prescription number. Several months later, the same participant, using a new prescription number, obtained 112 of the same oral birth control pills. The pharmacist reported that the 112 pills were an 88 day supply.

We questioned ESI regarding the pre-authorization for the oral contraceptive. They confirmed that no prior approval had been given and that the medication should not have been covered.

ESI's DUR did not identify the quantity and days supply for the 112 pills as exceeding the 90 day limit.

We conclude that the ESI DUR service may not be in compliance with the contractual agreement with the Association.

Prior Authorization

Certain new, expensive medications (as well as others selected by the plan sponsors) require prior authorization before a prescription can be accepted for payment. As discussed above, preauthorization is not being constantly applied. We conclude that the prior approval service may not be functioning.

Performance and Cost Saving Guarantees

ESI has agreed to penalties if the customer service call abandonment rate exceeds 8% and it the rate of generic drug dispensing is not at least 80%.

ESI provided no information regarding compliance with these guarantees.

Coordination of Benefits Claim Processing

ESI has agreed to process COB claims. The system used by the claim processors did not calculate the deductible amount. We understand a system enhancement has been prepared to rectify this situation. However, no COB claims were processed between August 10 and September 21,1998.

Conclusion

Based on the results of our review, we conclude that ESI may be in compliance with the terms of the Association contract except as it relates to the DUR service and the accurate processing of claims. We believe the DUR service may be ineffective in identifying abuse or inappropriate medications for the reasons cited above. The ESI claim processing system did not process claims with an accuracy rate similar to other systems with which we are familiar.

ESI may be in compliance with other aspects of the agreement. However, we received no documentation permitting us to reach a conclusion.

STATE CONTRACT

ESI and the State have entered into an agreement which was renewed as of January 1, 1998. The terms of the agreement relate to the specifics of the State's benefit plan provision. However, the terms of the Association agreement also apply to the State. We conclude that ESI is not complying with the terms of its agreement with the State in the same areas in which they do not comply with the Association agreement.

MUS CONTRACT

ESI entered into a renewed contract with MUS as of July 1, 1997. The scope of the MUS contract is similar to that of the contract with the Association. However, ESI has agreed to additional services, including:

- Incentive payments,
- Drug therapy management program,
- Member and Physician education and

- Formulary rebates.

All comments regarding the Association contract are applicable to the MUS contract review. However, the MUS plan does not have a deductible feature.

Incentive Payments and Rebates

ESI has been providing MUS periodic payments and rebates. Wolcott & Associates, Inc. conducted no audit services to confirm the accuracy of such payments.

Drug Therapy Management Program

ESI reported that the Drug Therapy Management Program is in place and physicians are being contacted and encouraged to use preferred drugs. We are aware that MUS is being charged for this service and conclude that the performance is in compliance with the contract.

Member and Physician Education

ESI has agreed to mail letters to participants and physicians designed to educate both groups about the use of lower generic medications. No documentation was provided to confirm that these service are still being performed. We understand this provision was removed from the Association's agreement. However, it is still part of the MUS agreement.

Conclusions

The comments made regarding the contract with the Association apply to the contract with MUS. In addition, we conclude the MUS and ESI should agree to continue to the education program or remove the provision from the contract.

FIB CONTRACT

ESI and FIB have entered into an agreement which was renewed as of January 1, 1998. The terms of the agreement relate to the specifics of the FIB plan provisions. However, the terms of the Association agreement also apply to FIB. We conclude that ESI is not in compliance with the terms of its agreement with FIB in the same areas in which they do not comply with the Association's agreement.

MPC CONTRACT

ESI and MPC have entered into an agreement. The terms of the agreement relate to the specifies of the MPC plan provisions. However, the terms of the Association agreement also apply to MPC. We conclude that ESI is not in compliance with the terms of its agreement with MPC in the same areas in which they do not comply with the Association's agreement.

VII - COORDINATION OF BENEFITS AND SUBROGATION

Both the agreement with the Association and the agreement with MUS contain provisions regarding the processing of prescription drugs for participants who have duplicate health care coverage. Neither contract contains a provision regarding ESI's involvement in subrogation activities. Information regarding our review activities and findings is presented below.

COB PROVISION

The COB provision in the agreements calls for ESI to "manage a Coordination of Benefits program for Members who have other coverage".

Under the agreements, the plan sponsors are to provide ESI information regarding other prescription drug benefits as part of the eligibility process. Those participants who have other coverage that has liability primary to the ESI coverage must then submit a paper claim plus an Explanation of Benefits form from the other coverage in order to receive reimbursement for prescriptions.

Claims involving COB are received in the claim department in Tempe, Arizona. Claims are not date stamped to show the received date. We were advised that processors hand write the received date on each document. However, the received date was not readily apparent to our auditors on most of the paper claims reviewed. Two people (one claim processor and the manager) are trained to process COB claims.

Information regarding the claim is entered into the system along with payment information from the primary plan's EOB. The system calculates the regular plan benefit and the payment amount, except as noted below.

CLAIM PROCESSING

COB claims are processed manually by ESI. On August 10, 1998 (the date initially scheduled for the commencement of our field work at ESI in Tempe) ESI management issued a memo to the claim department stating that the computer system was not calculating the deductible correctly for COB claims. Based on our observations during our field work, the situation had not been corrected on September 10, 1998, the last day of our delayed field work. ESI has confirmed that COB claim processing was resumed on September 21, 1998

None of our sample claim was a paper claim subject to the State plan's deductible.

COB DATA

COB data are not being provided to ESI. When the State first adopted the ESI program, COB data from BCBSMT was provided to ESI. However, no further information has been provided

by the State or BCBSMT.

COB data are not being provided to ESI by or on behalf of any of the other 3 plan sponsors.

As a result, the COB provision is ineffective except for those individuals employed by the State whose COB data were provided to ESI several years ago.

We supplied BCBSMT with a listing of claims in our sample for the State, MUS and MPS and requested that they provide us with information from their files regarding the existence of other health care coverage. Our findings are presented below.

Sponsor	Claims	Other Plan Primary
State	229	4
MUS	65	0*
MPS	28**	2

*ESI data tended to show employee name rather than patient name. As a result, the findings are inconclusive.
**List for MPS contained less than all claims in sample.

Based on the results of our review, we conclude that the Plan Sponsors are not actively providing ESI the information to manage the COB provision. We further conclude that claim costs, in aggregate, would be lower for the State and MPS, if the COB information were made available to ESI.

No data were available for MUS and FIB. However, it is reasonable to conclude that savings are available.

SUBROGATION

Neither the ESI agreement with the Association nor MUS contain a provision regarding subrogation. We discussed the subject of subrogation with Mr. Doug Menendez, Audit Director for ESI in St Louis. Mr. Menendez advised us that ESI does not participate in subrogation activities.

VIII - OTHER CLAIM ISSUES

Discussion regarding other claim issues is presented below.

COMPLETENESS

Electronic claims are filed by the pharmacist at the point of sale. To complete the transaction, the pharmacist must supply the pharmacy number, prescription number and the participant's Social Security number. The pharmacist must then also identify the family member and enter information regarding the pharmaceutical being dispensed.

Failure to supply the needed information causes the ESI system to suspend the transaction. As a result, the system forces the pharmacist to provide complete information for each claim.

Participants filing paper claims must complete a form, list all prescriptions and submit the pharmacy receipts. If the claim involves COB, a copy of the other plan's EOB must also be attached.

Claim processors are trained to review each paper claim. If needed, missing items are requested prior to processing the claim.

We reviewed the submitted data for each of the claims in our sample and compared the data to the information in the health care plan records for each of the four plan sponsors. While the information appears to have been complete enough to process claims, we noted the following:

- Birth dates recorded in the claim records for several participants were listed as -0-. Failure to record an actual birth date will preclude the ESI system from determining if the medication is appropriate or covered by the plan based on the age of the patient.

- Patient names and patient sex as recorded in the claim records did not always agree with the client's records. Failure to record accurate data will preclude the ESI system from properly performing drug utilization reviews.

BENEFIT STRUCTURE

We reviewed each plan document for the period covered by the audit to gain information regarding the appropriate deductible, copay and out-of-pocket limit. We also obtained information regarding the use of formulary medications and limits on number of days supply, pre-approval procedures and excluded drugs.

The claims in our sample were reviewed to determine that each was paid according to the benefit structure for each plan. We have discussed our findings regarding benefit structure along

with the results of our recalculation of each sample claim. Findings regarding benefit structure are restated below along with information not directly related to the sample claims.

Days Supply

ESI paid a claim for 112 oral contraceptive pills. The pharmacist recorded the days supply as 88 days. If the patient takes one pill per day, 112 pills will last 112 days. The system's logic does not appear to measure the volume of medication against the days supply as reported by the pharmacist. As a result, the 90 day supply limit and the 100 pill limit can be circumvented.

Refill Timing

The same claimant, referred to above, had received a 90 day supply of the same oral contraceptive on January 24, 1997 and a refill for a 30 day supply on January 30, 1997. ESI system edits failed to identify the transaction on January 30, 1997 as being too soon.

We appreciate the fact that January, 1997, precedes our audit period. However, the information indicates that the edit was not working. We have no information that assures us that it was working during the audit period or is working now.

Deductible and Copay

Several sample claims resulted in a deductible and copay which, in total, exceeded the out-of-pocket limit for the plan year. ESI advised us that the system cannot limit the out-of-pocket amount properly if the claim is subject to the deductible and on the same claim the out-of-pocket limit would be reached.

Copay

One of the sample claims had been processed using the copay amount that had been in effect during the prior plan year. This claim was processed during the first few weeks of the new year and appears to be the result of a failure to update the plan provisions in the system on a timely basis.

An additional claim was processed using a copay that is not one of the three copays used by the State's plan

Deductible on COB Claims

As of August 10, 1998, processors were advised that the system could not properly calculate the deductible for claims involving COB. As of that date (the same date as our field work in Tempe was originally scheduled to begin) processing of COB claims was suspended. As of September 10, 1998, the last day of our actual field work in Tempe, the problem hand not been solved and COB claims had not been processed for a month. ESI has assured us that the problem has been corrected

and that COB claims are now being processed.

Viagra - MUS

The MUS advised ESI by facsimile transmission on May 13, 1998, that they did not wish to cover Viagra. We reviewed a memo in Tempe stating that the system had been updated to exclude Viagra for the MUS plan. The effective date of the change was September 1, 1998, three and a half months after the date MUS notified ESI.

MUS - Copay

The MUS plan charges a $10.00 copay for generic medications, sole source brand name medications with no generic equivalent and brand name drugs on the formulary. Other brand name medications are subject to a $20.00 copay.

Early in the audit period, ESI had been charging a $20.00 copay for Prozac. In March, ESI began to charge a $10.00 copay for Prozac. ESI stated that the change was made after MUS supplied a list of medications subject to the $10.00 copay.

MUS stated that the provision has remained unchanged since the prescription drug plan was established.

Duplicate Payments

The only duplicate payment identified during our audit was a paper claim that was paid twice in August, 1997, for a participant under the MUS plan. Copies of the invoices were provided to ESI with a request for information as to how the duplicate payment occurred.

We received no explanation other than a statement that the second payment to the participant was actually identified prior to payment and was not mailed to the participant. The second invoice to MUS was mailed, however, and MUS paid both invoices.

We have not received confirmation that the overpayment has been repaid to MUS.

Year 2000

ESI has not completed their work to make the claim system and their organization compliant with the year 2000 date change. However, in a two page letter, we were assured that ESI is working toward a goal of being in compliance before the end of 1999.

IX - LOGIC AND OTHER TEST RESULTS

This section presents the results of test claims submitted to the ESI claim system as a method of assessing the system's ability to identify inappropriate transactions.

LOGIC CLAIMS

We created a total of 12 fictitious claims (six paper claims and six electronic claims). Working with a claim processor in the claim department and a specialist in the training area in Tempe, these claims were submitted to the system for processing. The paper claims were submitted to the live system, however, they were not released for payment. The electronic claims were submitted to the system in a test mode. Each claim was then resubmitted twice; once with the billed amount changed and once with the provider code changed (or provider name changed for the paper claims).

OTHER CLAIM TESTS

We also created a series of additional fictitious claims (5 each) for the following situations.

- Claims for terminated employees or retirees.
- Claims for a terminated dependent.
- Claims from a fictitious provider.
- Claims that had been paid primary by another benefit plan for an individual with no documented COB data.
- Claims for drug prices in excess of the contract price.
- Claims for medication inconsistent with the patient's sex.
- Claims filed once by the pharmacist and then by the participant.

FINDINGS

Our findings are presented as **Exhibit C** and discussed below.

Logic Claims

The system is designed to receive claims electronically from a pharmacist and reimburse that pharmacist. Our first logic test involved resubmitted claims by the same pharmacist on the same date with a different ingredient cost. The system identified these claims as duplicates.

However, if the claim is submitted with a different pharmacy number, the system will not recognize these claims as duplicates. The control function regarding such transactions is that payment would be made to that pharmacist whose address corresponds to the pharmacy number, if that pharmacist is a member of the ESI program. The original pharmacist would not be paid twice and, as a result, would have no incentive to make a second submission with a second pharmacy number.

Under the paper claim system, the claim processor attempts to locate the provider number in the ESI system. If the pharmacy is not an ESI participating pharmacy, a dummy pharmacy number is used to permit the claim to be processed.

If a paper claim is resubmitted with the billed amount changed, the system will identify the claim as a duplicate. However, if the pharmacy number is changed (from an ESI participating pharmacy to the dummy number) the claim will be processed again.

During our test work on ESI invoices at MUS, we identified a paper claim that had been paid twice. ESI did not provide any information as to how the second payment was made. However, they assured us that a refund would be made to MUS. (As of the date of this report, we have not received any confirmation of the refund.)

Claim For Terminated Individuals

If the termination date for an employee or dependent is recorded in the claim system, no claims will be paid if the dispensing date follows the date of termination. All 10 of such test claims were rejected.

Claims From a Fictitious Provider

The system will only process electronic claims submitted by pharmacists that participate in the ESI program. Claims from non-participating pharmacists will be rejected. All 5 test claims for a non-participating pharmacy were rejected.

However, fictitious claims can be processed under the paper claims system, if a properly completed pharmacy receipt is submitted and the claim is not selected for post pay review.

COB Claims

ESI has established a subgroup for State employees whose other insurance information has been provided to them. If the other coverage is primary, the system will preclude the pharmacist from processing the claim using the on-line system.

However, ESI will process all claims for all other individuals without regard to the existence of other insurance even if the claim is a paper claim submitted by the participant. The only

participants to whom the COB provision applies are those for whom ESI has received COB information.

Excessive Price

We submitted claims for prescriptions using ingredient costs that were in excess of the contracted ingredient. The ESI system properly reduced the payment to agree with the contractual price.

We identified two claims in our audit sample that were paid using an ingredient cost other than the contractual price. Both were mail order claims from Buttrey. ESI had processed these claims based on the AWP in effect as of the date ESI received the bill from Buttrey rather than the date the prescription was dispensed by Buttrey.

ESI advised us that this is their practice. However, this practice is not described in the agreements with the Association or MUS. ESI uses the AWP on the date the prescription is filled for all network claims and paper claims which are processed on the same basis as network claims. The use of AWP as of the date ESI receives the claim is inconsistent and not described in the Agreements.

Drug Inconsistent with Patient's Sex

We submitted 5 fictitious claims for sex specific medication using the incorrect sex for the patient.

The ESI system failed to identify this inconsistency in 3 of the 5 test claims.

Claims filed by Pharmacist and Participant

Only ESI participating pharmacists can submit electronic claims. At the completion of the transaction, the patient receives a receipt for the deductible and/or copayment paid. The patient should not receive a receipt for retail cost of the pharmaceutical or the amount payable by the plan sponsor.

If a participant does obtain a receipt for the actual cost of the pharmaceutical and files a paper claim, the payment procedure requires the processor to identify the participating pharmacy's pharmacy number and use it in the processing of the paper claim. The system will reject such claims as duplicates.

We submitted 5 test claims to the electronic system and then attempted to submit them again as paper claims. When the pharmacy number was entered, the system rejected all 5 claims as duplicates.

However, if the paper claims were entered using the dummy number (used for non-member pharmacies), a duplicate claim would be paid.

SUMMARY

Based on our test results, we conclude that the ESI system is effective in identifying erroneous claims except in the following areas:

- Paper claims involving the use of the dummy provider number.
- COB claims for individuals whose COB information has not been previously provided to ESI.
- Drugs which are inconsistent with the patient's sex.

While the ESI system cannot identify duplicate claims filed electronically using separate pharmacy numbers, we conclude that the risk of such events appears to be low.

X - CONCLUSIONS AND RECOMMENDATIONS

We performed our audit based on the services requested and agreed upon in our audit contract. Claim payment accuracy was determined based upon the provisions in the documents describing the prescription drug benefit plans of each plan sponsor. Determinations of compliance with technical aspects of the services provided by ESI were measured against the language in the agreements between the ESI and the various plan sponsors and the Association.

Policies and procedures employed by ESI were not viewed as appropriate documentation if they were not supported by documentation agreed to by the plan sponsors and/or the Association.

Presented below are our conclusion and recommendations regarding those aspects of the plan which we believe could benefit from revision.

CLAIM PAYMENT

Presented below are the comments and recommendations related to claim payments.

AWP Pricing

The agreements all call for the payment of prescription claims based on AWP (or a lower amount, if established by ESI). Network claims are based on the most current AWP in the system as of the date the prescription is filled. Paper Claims are processed on the same basis as network claims - AWP as of the date the prescription is filled.

The Buttrey mail order prescriptions, however, are paid based on the AWP in effect on the day ESI is billed by Buttrey. This inconsistency is not described in any of the agreements.

We recommend that ESI either process such claims on a basis consistent with other claims or amend the agreements to provide for a payment method that agrees with their practice.

Copayment and Deductible

ESI is not capable of limiting the out-of-pocket expenses for a participant or family to the contractual amount. ESI management appeared to be aware of this system limitation when we discussed it with them in Tempe. This system limitation appears to place ESI in violation of their agreement to administer the benefit plan sponsored by the State.

We recommend the following:

- ESI should immediately revise their claim processing software so that it is capable of processing plan claims as agreed upon with the State.

- ESI should immediately begin a program of manual review of all State claims to assure that out-of-pocket limits are not exceeded. This manual review should continue until the software revision is proved effective.

- ESI should immediately review all State claim history to identify individuals and families that have been charged more than the contractual copay and deductible. Refund checks should be sent to each over charged person.

- ESI should provide a monthly progress report to the State until these steps have been completed.

Slow Copay Revision

The MUS increased the copay amounts as of July 1, 1997. Our review of claim history indicates that ESI did not revise the plan provisions in the claim system until the third or fourth week of July.

We recommend that ESI review MUS claim history to determine the magnitude of such errors. A refund check should then be issued to MUS for the full value of the difference in copay amounts.

State Copay Percentage

ESI paid one of the State claims in our sample using a 25% copay. We have been unable to find any documentation supporting the use of a 25% copay.

We recommend that ESI produce their supporting documentation for the use of a 25% copay. If none exists, ESI should refund overpayments to the State.

Prior Approval Drugs

ESI confirmed that one sample claim for birth control pills had not been approved prior to payment. We make the following recommendations:

- ESI should research all claim history to identify all drugs subject to prior approval when such approval was not obtained. Each plan sponsor should be reimbursed for the sum of the overpayments.

- ESI and each plan sponsor should review the prior approval provision and agree to the drugs that should be subject to prior approval.

- ESI should demonstrate that the prior approval edits are functioning properly.

- ESI should provide monthly reports of progress until the project is completed.

Paper Claims

Each of the agreements calls for payment of paper claims (not COB) using a reimbursement no less favorable than a system processed claim for a network pharmacist.

In actual practice, ESI has paid some paper claims based on the actual billed charges. One claim in our sample was a paper claim where the payment was based on billed charges that exceeded AWP less the discount.

We recommend the following:

- ESI should begin processing paper claims in compliance with the agreements.
- ESI should research the claim history for all plan sponsors to identify over paid paper claims. Refunds should be issued to each sponsor.
- ESI should provide monthly status reports until the refunds have been issued.

COB CLAIMS

The State is the only one of the four plan sponsors that has ever supplied COB data to ESI. COB data from the State were provided once and the data have never been updated.

We suggest that all four sponsors review this plan provision. If they determine that the COB provision should be utilized, periodic COB data should be provided to ESI so that savings can be obtained.

PARTICIPANT CONFIRMATIONS

We experienced significant resistance to our efforts to obtain confirmations from plan participants. We believe confirming the receipt of prescriptions is an important control factor for all four sponsors to utilize. We also believe participants should be encouraged to respond to confirmation request.

A failure to confirm the receipt of a prescription may indicate that the drug was not dispensed or it may be an indication of fraud or other inappropriate activity.

We suggest the following procedures be employed in future years:

- Confirmations should be requested on plan sponsor letterhead to emphasize the official nature of the correspondence.

- Participants who do not respond to the confirmation request should be notified that access to the prescription drug program will be restricted until the requested information is provided.

ELIGIBILITY

The difficulties and delays in effecting coverage terminations by the State and the MUS appear to be excessive as compared to the process employed by other health care benefit claim processors (including pharmacy benefit claim processors) with which we are familiar.

We have suggested a solution to the State's problem on pages IV-1 and IV-2. ESI has offered another solution. ESI has also defended their 3 day delay in processing MUS eligibility charges by describing each step in the process.

We make the following recommendations regarding the processing of coverage terminations:

- ESI should agree to a workable procedure with the State so that all coverage terminations are effective in the system as of the date the coverage termination is effective. We see no excuse for the use of any other date, if ESI is notified in advance.

- ESI should be able to effect a transaction in less than 72 hours for MUS. Clients that enter eligibility to the ESI system using the on-line system can make instantaneous changes. We see no reason why ESI, using its own system, needs 72 hours.

DUPLICATE CLAIM OVERPAYMENT

During the week of August 3, 1998, we identified a duplicate invoice paid by MUS for a paper claim. We brought this claim to the attention of ESI's internal audit department in St. Louis prior to our field audit in early September. We also supplied copies of both invoices to St. Louis and Tempe.

ESI, in their last letter to us on the subject, has indicated that they are researching the situation.

We recommend ESI refund the overpayment to the MUS. They can then research the situation until they discover how the claim was processed twice and two invoices were issued to the MUS.

DATE STAMPING

The standard industry practice is to place a date stamp on each piece of incoming mail to record the date the document was received. Manually writing a date on a document without any reference to what that date signifies is ESI's practice. However, it is far from industry standard and does not appear to be consistently applied by ESI.

We recommend ESI invest in a date stamp and use it to record the received date for all paper claims.

DRUG UTILIZATION REVIEW

We were unable to confirm that the DUR system was effective. We reviewed several activity reports for participants that indicated that refills were processed too soon after the initial prescription was filled. Test claims for medication inconsistent with the patient's sex were processed to completion.

ESI maintains that their DUR system is working properly.

We recommend that ESI provide a detailed report of DUR activity during the audit period to support their statement that the DUR system is effective. Illustrations of each of the contractual edits should be included in the report.

OTHER CONTRACTUAL ISSUES

We made several comments to the effect that ESI did not provide documentation regarding performance of services agreed upon in their contracts with MUS and the Associations. ESI responded by stating that reports are issued to the plan sponsor or that the agreement was effective on January 1, 1998.

We are unaware of any information provided to any of the plan sponsors regarding pharmacy audits or performance measured against guarantees.

We suggest each sponsor request that ESI provide reports on a quarterly basis regarding their guaranteed performance and the results of pharmacy audits in Montana.

Exhibit A

EXPRESS SCRIPTS PHARMACY CLAIMS
1997 - 1998 CLAIM AUDIT
DESCRIPTION OF ERRORS

Description	Date Filled	Drug NDC	Plan Cost	Audited Amount	Difference
AWP less discount is lower than billed ingredient cost.	12/30/97	49490066	172.34	168.78	3.56
AWP less discount is lower than billed ingredient cost.	4/29/98	74621513	330.59	320.30	10.29
ESI charged deductible and/or copay in excess of plan year maximum.	1/27/98	50242-0072	2292.52	2551.50	-258.98
ESI charged deductible and/or copay in excess of plan year maximum.	4/10/98	00006-0963	233.30	244.64	-11.34
ESI charged incorrect copay.	5/7/98	00002-7515	25.49	23.79	1.70
112 birth control pills to be taken one per day. Pharmacist reported an 88 day supply. DUR is not effective.	8/5/97	00062-1796	82.47	0.00	82.47
Paper claim paid based on submitted cost. Plan states that member will be reimbursed as if the claim had been a network claim.	3/31/98	0077731052	84.50	60.24	24.26
ESI charged incorrect copay.	7/3/97	00049-4910	55.89	50.89	5.00
Total			3,277.10	3,420.14	-143.04

Exhibit B

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
CLAIM PAYMENT TIME

Information regarding the time required for ESI to pay the pharmacist following the dispensing of a prescription under the electronic claim system. No data are provided for paper claim payment time

MEASURE	STATE	MUS	MPC	FIB
Mean	18.8	25.8	27.6	21
Median	24	24	22	18.5
Mode	21	17	22	17

Percent Paid on Day Following Dispensing for State

Day	# of Claims	% of Claims
1 thru 12	0	0.00%
13	2	1.69%
14	0	0.00%
15	3	2.54%
16	0	0.00%
17	4	3.39%
18	9	7.63%
19	5	4.24%
20	8	6.78%
21	12	10.17%
22	8	6.78%
23	4	3.39%
24	6	5.08%
25	3	2.54%
26	7	5.93%
27	8	6.78%
28	6	5.08%
29	6	5.08%
30	8	6.78%
Total	99	83.90%

Percent Paid on Day Following Dispensing for MUS

Day	# of Claims	% of Claims
1	1	1.90%
2 thru 16	0	0.00%
17	6	11.11%
18	5	9.20%
19	4	7.40%
20	1	1.90%
21	2	3.70%
22	4	7.40%
23	0	0.00%
24	4	7.40%
25	3	5.60%
26	3	5.60%
27	4	7.40%
28	3	5.60%
29	2	3.70%
30	1	1.70%
Total	43	79.16%

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
CLAIM PAYMENT TIME

Percent Paid on Day Following Dispensing for MPC

Day	# of Claims	% of Claims
1 thru 9	0	0.00%
10	1	3.70%
11	0	0.00%
12	1	3.70%
13 thru 16	0	0.00%
17	2	7.40%
18	1	3.70%
19	0	0.00%
20	4	14.80%
21	0	0.00%
22	5	18.50%
23	3	11.11%
24	0	0.00%
25	2	7.40%
26	1	3.70%
27	3	11.11%
28	0	0.00%
29	1	3.70%
30	1	3.70%
Total	25	92.52%

Percent Paid on Day Following Dispensing for FIB

Day	# of Claims	% of Claims
1 thru 16	0	0.00%
17	2	50%
20	1	25%
21	1	25%
Total	4	100%

Exhibit C

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
RESULTS OF SYSTEM TESTS

TESTS	RESULTS
LOGIC TESTS	
Billed Amount Electronic	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Claim 6	Pass
Billed Amount Paper	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Claim 6	Pass
Pharmacy Number Change - Electronic	
Claim 1	See comment
Claim 2	See comment
Claim 3	See comment
Claim 4	See comment
Claim 5	See comment
Claim 6	See comment
Pharmacy Number Change - Paper	
Claim 1	Fail
Claim 2	Fail
Claim 3	Fail
Claim 4	Fail
Claim 5	Fail
Claim 6	Fail

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
RESULTS OF SYSTEM TESTS

TESTS	RESULTS
Terminated Employee	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Terminated Dependent	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Fictitious Provider	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
COB Claims (Paper)	Fail
Claim 1	Fail
Claim 2	Fail
Claim 3	Fail
Claim 4	Fail
Claim 5	Fail
Excessive Price	Pass
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
RESULTS OF SYSTEM TESTS

Drug Inconsistent With Patient's Sex	
Claim 1	**Fail**
Claim 2	**Fail**
Claim 3	**Fail**
Claim 4	**Pass**
Claim 5	**Pass**
Claim Field By Pharmacist and Participant	
Claim 1	**Pass**
Claim 2	**Pass**
Claim 3	**Pass**
Claim 4	**Pass**
Claim 5	**Pass**

Express Scripts ◆ ValueRx

1700 North Desert Drive
P.O. Box 52161
Phoenix, AZ 85072-2161
602-225-0005
http://www.express-scripts.com
http://www.valuerx.com

11/20/98

EXHIBIT D

Ray Wolcott
Wolcott & Associates, Inc.
10977 Granada Lane, Suite 103
Overland Park, KS 66211

John Fine
Financial Compliance Audit Manager
Legislative Audit Division
P.O. Box 201705
Helena, MT 59620

Re: State of Montana Audit
Official Response

Dear Mr. Wolcott:

Following is our Official Response to your Final Report on the above audit.

I Introduction

I-2 Paragraph 1. Wolcott and Associates were in violation of the signed Confidentiality Agreement entered into with Express Scripts/ValueRx (ESI/VRx). This violation is what caused a delay, not an objection by ESI/VRx regarding the use of an outside vendor.

II Statistical Claim Audit Results

II-1 Paragraph 3. Wolcott and Associates were in violation of the signed Confidentiality Agreement entered into with ESI/VRx. This violation is what caused a delay, not an objection by ESI/VRx regarding the use of an outside vendor. This does not warrant an increased sample size.

II-2 Definition of Error. An error should be defined as any claim when the Sponsor was not billed in accordance with the plan document provisions. ESI/VRx contracts separately with the pharmacies. Payments to the pharmacies is not an element of the client contract.

Audit Results.

The audit lists two claims as paying inappropriately based on AWP discounts. Both these cases relate to claims paid at Buttrey's pharmacy. Buttrey's was set to pay at the AWP price in effect at the time of billing, not at the time of fill in the pharmacy. While we agree that this set-up is not consistent with the other network pricing based on fill date, there is nothing contractually requiring that payment be based on filled date and these claims can not be considered errors based on the auditor's definition of an error.

DUR will not identify 112 birth control pills for an 88 day supply as an error. More than one pill a day may be prescribed by physicians for clinical reasons. ESI reviews all claims where the dosage is twice the amount recommended by the manufacturer's guidelines, and all claims over $100.

For the State only, diabetic supplies are paid at a 25% copay. This plan design has been in effect since the State began processing with us.

For the State only, member submitted claims are paid on a negotiated rate and the member pays a higher copay than when they use a network provider.

This leaves three claims in error. This represents a frequency of payment error of 1.1%. One case was an overpayment and two were underpayments.

II-3 Population Data. This entire section needs to be adjusted by Wolcott & Associates.

Adjustment Entries. Bullet 2. Regarding network claim adjustments, the pharmacy does not inform ESI/VRx of the reason for the adjustment. ESI/VRx does maintain data for member submit adjustments.

Adjustment Entries. Bullet 3. No administrative fee is charged to the client if the claim is reversed prior to seven days from the original transaction date, although ESI/VRx incurs an administrative cost to process the transaction. If a claim is reversed after the seven days, the administrative fee is not refunded to the client unless the claim has been moved to our history file. Claims older than two months are moved into a history file. Once a claim is in the history file, system logic does not split off the administrative fee from the claim cost. Therefore, if a history claim is reversed, the client is reimbursed the entire amount of the claim, including the administrative fee.

II-4 Types of Errors. Montana University requested that we add Buttrey Drugs to our pharmacy network. Therefore, there is a separate contract between Montana University and Buttrey Drugs. In November 1998, a request for change was entered at our Tempe facility to change the way ESI/VRx bills the Buttrey claims. This change is to calculate the AWP pricing based on fill date of the claim, and not bill date, which is in conflict with the way the AWP pricing is calculated for other pharmacies in the network.

Deductible and Copay. ESI/VRx will implement a system change which will calculate the out-of-pocket dollars prior to calculating the copay. This is scheduled for completion in 1QTR99.

IV Eligibility

IV-1 State of Montana. Problem. Paragraph 1. The purpose of a reconciliation tape is to term any member who is not present on that tape. It is true that a term date equal to the tape processing date will slot in the member's term date field for any member who is not listed on the reconciliation tape.

Paragraph 3. A couple of solutions to this would be: (1) for the State of Montana to inform their Account Manager to slot the last day of the month as the termination date for the reconciliation tapes, or (2) to send ESI/VRx actual termination dates with their eligibility records.

IV-2 Montana University System. Paragraph 2. Following is a response to your comment regarding a 72 hour delay in processing eligibility data.: Day 1 - The eligibility tape is received by ESI/VRx and sent to Operations for a prepass of the data. The prepass is typically run during the evening hours. This prepass generates a report listing the changes to the eligibility data that would take place if the tape were to be applied to our system. Overnight or the next morning the prepass report is delivered to the Eligibility department for review. Day 2 - The report is reviewed the day following the prepass by the Eligibility Representative responsible for this client. After the Eligibility department has reviewed the prepass report, and it looks okay to apply the data, a request is submitted to our Operations department to apply the tape to our system. The data will be applied to our system during the evening hours. Note: If after reviewing the prepass report the Eligibility Representative has issues that need to be discussed with the client prior to applying the data, a call or fax to the client is made the same day the prepass report is reviewed so that the issues can be resolved and the data can

be applied as soon as possible. This process can be modified to bypass the prepass step so that the data is entered directly into the system.

Eligibility Verification. Paragraph 2. Wolcott & Associates provided an eligibility listing to us which reflected their findings of incorrect birth dates and sex codes. The member ID #s provided by Wolcott for some of the members were not the member's correct ID # reflected in our system. Upon researching this listing, no errors were found in our system. The data had been in the system correctly since prior to the start of this audit.

V Claim payment and ESI Reimbursement

V-1 Claim Payment Time. Paragraph 6. ESI/VRx contracts separately with the pharmacies. The time required to pay pharmacies is not an element of the client contract.

Paper Claims. Paper claims are date stamped upon receipt by ESI/VRx. This date may be hand written, typed, or date stamped. Standard processing is to use a date stamp. Since copies were provided to the auditors, the date stamp did not show clearly and the date was hand written over the stamp so that the reviewers could clearly read the dates. Infrequently, the date may be typed or hand written when a stamp is unavailable.

V-2 Overall Results. Paragraph 1. ESI/VRx contracts separately with the pharmacies. The time required to pay pharmacies is not an element of the client contract.

V-3 Montana University System. Paragraph 3. This situation resulted when a manual check was cut twice to a member. Manual checks are the only checks not subject to duplicate payment edits. The claims processor is required to manually determine if a check has been cut to the member previously. In this case the processor made a mistake and cut the check twice. The credit has been applied to MUS.

VI - Express Scripts Compliance

VI-2 Bullet 1. Accurate Processing of Claims. Currently, on the qualifying claim our system does not know to stop at the member's out-of-pocket dollar amount. We have scheduled a change to be completed by the end of 1QTR99 which will change the way this is processed. The member's out-of-pocket dollars will be calculated prior to calculating the copay.

Bullet 3. COB Claim Delays. Paragraph 1. As of September 21, 1998, we have been able to process deductibles for COB claims through our computer system. Prior to this time, the deductible for the claims was calculated manually by the claims processors. During the cutover from manual to system processing, we were unable to process COB claims for the period from August 10, 1998 - September 21, 1998. There were approximately 150 claims which were held up during this period of transition.

Audit of Participating Pharmacies: Paragraph 2. ESI/VRx's Provider Relations department provides the results of pharmacy audits directly to the client.

VI-3 Paragraph 1. (Following bullets) Previously addressed in IV-2 Eligibility Verification.

Paragraph 2. Documentation previously provided to Wolcott & Associates that we researched this and found that one Rx was dispensed for the cardholder and one for the spouse.

Paragraph 3. This duplicate claims issue is not a duplicate claim, but a duplicate manual payment. Details of the situation are described previously.

Paragraph 4. Contract specifies that ESI will perform edits for "exceeding maximum dosage". One member received 112 birth control pills for an 88 days supply. The plan design limitation is for 90 days, so an 88 days supply would have been accepted. If the claim had been over $100 it would have been flagged for review by the provider relations team. It is not unusual, for clinical reasons, for a doctor to prescribe more than 1 birth control pill a day for a period of time. Had the doctor prescribed more than twice the mfg. recommended dosage, it would have been flagged by the high dose edit.

Paragraph 7. The ESI/VRx DUR is in compliance with the contract with The Association.

Prior Authorization. Paragraph 1. Neither Pulmozyme 1 mg/ml nor Imitrex 50 mg tablets require prior authorization according to the plan design in place for Montana University. Therefore, there was no prior authorization required. If the sponsors want to define a "high limit" dollar amount which would require all drugs over a certain amount to be prior authorized, we can certainly set that up.

Performance & Cost Saving Guarantees: Paragraph 1. The Montana University contract does not contain any guarantees regarding a Customer Service call abandonment rate. The Montana University contract guarantees a minimum generic drug dispensing rate through participating pharmacies (but excluding the mail service pharmacy) from multi-source drugs of 75% of those that have an FDA A or AB rated generic available. The Association contract (which became effective 1/1/98), guarantees that the call abandonment rate will not exceed 8% in any quarter unless the failure is due to a failure in a third-party telecommunication system. Confirmation will be provided quarterly. The Association contract also guarantees a minimum generic drug dispensing rate through participating pharmacies (but excluding the mail service pharmacy) from multi-source drugs of 80% of those that have an FDA A or AB rated generic available.

Paragraph 2. The Association contract (which became effective 1/1/98), guarantees that the call abandonment rate will not exceed 8% in any quarter unless the failure is due to a failure in a third-party telecommunication system. Confirmation is provided quarterly, directly to the client.

VI-4 Coordination of Benefits Claim Processing. Previously addressed. See response to VI-2 Bullet 3 - COB Claims Delays.

Conclusion. DUR Service - ESI/VRx agrees to provide standard DUR messaging to the pharmacies. The DUR messaging can be done without patient medical history because it is specific to the patients drug history or appropriate dosing as indicated from standard dosing guidelines. Messaging is soft messaging (except for Duplicate prescription which stops the Rx) and thus it allows professional judgement from the pharmacist to decide if action needs to be taken.

State Contract. ESI is in compliance with the terms of its Agreement with The State.

VI-5 Member & Physician Education. Paragraph 1. This provision has been removed from the new contract with the Montana Association of Health Care Purchasers. All network providers are required by contract to offer members the generic in place of a brand product.

1st Interstate Bank Contract. ESI is in compliance with the terms of its Agreement with 1st Interstate Bank.

VII Coordination of Benefits and Subrogation

VII-1 Claim Processing. Paragraph 1. Previously addressed. See response to VI-2 Bullet 3 - COB Claims Delays.

VIII Other Claims Issues

VIII -1 Completeness. Bullet 1. Previously addressed in IV-2 Eligibility Verification.

Bullet 2. Previously addressed in IV-2 Eligibility Verification.

VIII-2 Days Supply. No Prior Authorization in the system. There should have been a P/A for this item to pay.

Refill Timing. Paragraphs 1 & 2. Even though this precedes the audit period, it was researched and found that on the example provided for a refill too soon question for patient Howard, that the pharmacist would have received a DUR duplicate therapy message and it is up to the discretion of the pharmacist whether or not to fill the Rx.

Deductible and Copay. Previously addressed. See VI-2 response.

Copay. The Montana University contract in effect at the time this claim processed had a copay charge of $5.00 on single source brand drugs and this item is a single source brand drug. This was responded to in our letter to Wolcott & Associates dated 10/13/98.

Deductible on COB Claims. Previously addressed. See response to VI-2 COB Claim Delays.

VIII-3 Viagra / MUS. Paragraph 1. Viagra was implemented as an excluded drug on 6/1/98. Documentation of this implementation was forwarded to Wolcott & Associates on 11/5/98.

MUS Copay Discrepancies. Paragraph 2. Up until 7/1/97, brand medications, and this would include Prozac, were charged a $20 copay. On 7/1/97, the copay changed to $10 for generics and single source brands. Since Prozac is a single source brand, the copay moved to $10. We have never received a "list" of medications from the client instructing us to change the copays.

Duplicate Payments. Paragraph 3. Re Invoices MN00774001 & MN00773001, our Tempe facility has requested a credit to be issued on this duplication.

IX Logic and Other Test Results

IX-2 Findings. Logic Claims. Paragraph 3. All claims, manual, network and mail, are subject to our back end processing DUR editing for duplicate claims. The case

cited, changing a pharmacy number, would be caught when the system goes through the DUR edits. Since this was a test claim, it was adjudicated, but not processed through DUR editing.

Paragraph 4. The member submit claim system is designed to accept claims from "non-participating" providers, and are typically submitted when a member is out of town and out of network. This benefit option is at the discretion of the plan sponsor.

IX-3 Drug Inconsistent with Patient's Sex. Paragraph 1. Supporting documentation was requested from Wolcott & Associates, but not provided, on the fictitious claims so that we could research them.

IX-4 According to the Claims department supervisor who conducted these on-site tests with Wolcott & Associates, paper claims entered using the dummy number did not pay twice as stated in Wolcott's audit report. It is the Rx number and the fill date that the system looks for on potential duplicate claims, and not the NABP number.

X Conclusions & Recommendations

AWP Pricing. We agree that the payment for Buttrey mail order prescriptions should be based on the fill date and have changed this in the system.

Copayments and Deductible. Express Scripts/ValueRx is capable of limiting the out-of-pocket expenses for a participant or family to the contractual amount. In the case of a qualifying claim the copayment is calculated prior to determining the out of pocket expense. The system has always processed this way, and all our clients are handled in the same way. The system will be modified in QRTI to process to the specifications requested by the auditor. We will identify all state claims that are impacted by this issue and reimburse members as appropriate. We will identify indiviuals and families that have been charged more than the contractual copay and deductible and reimburse members as appropriate.

Copay Revision. We will assess the magnitude of the error and provide a refund to Montana University for the full value of the difference in copay amounts. Many of these adjustments have already been made with manual checks cut to the members.

State Copay Percentage. Diabetic supplies are paid at a 25% copay. This copay has been in effect since the original set-up of the State's benefit. This can be changed if it is not the copay desired by the plan sponsor.

Ray Wolcott

Prior Approval Drugs. We agree that one claim for birth control was paid to a member and that no prior authorization is currently in the system for this script. This was an unusual situation where the member regularly received this product and numerous prior authorizations are in the system for prior and subsequent fills.

The only "missing" prior authorization (PA) is for the audited claim. We are unable to explain this anomaly, but are completely confident that all drugs requiring a PA require a PA to process. The most likely scenario is that the override was erroneously deleted from the system. The PA function is a very basic function that is tested regularly by our testing department and audited by numerous clients. We are completely confident that this functionality works and will work with the plan sponsors to provide additional testing or review to validate this function.

Eligibility. We are able to apply the data to the system immediately, and the 72 hour delay results from the prepass and QA process previously described. We are able to bypass this QA process at the written request of the plan sponsors.

Date Stamping. We already use a date stamp as standard practice.

DUR. We are willing to work with the plan sponsors to review the DUR edits currently in effect.

Other Contractual Issues. We will provide quarterly reports on guaranteed performance.

As suggested by the auditors, we will provide status updates on a monthly basis to the plan sponsors through Glen Leavitt and Bill McDonald.

Respectfully,

LeAnn Dale
Director Client Services
Express Scripts/ValueRx
1700 North Desert Drive
Tempe, AZ 85281

cc: Dale Chamberlain
Mabel Chen
Lisa Frey
Doug Menendez

via fax: Glen Leavitt, Bill McDonald, Joyce Brown

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

MARC RACICOT, GOVERNOR

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STATE OF MONTANA

(406) 444-3871

HELENA, MONTANA 59620-0127

November 20, 1998

EXHIBIT E

Mr. Ray Wolcott Jr., President
Ray Wolcott & Associates Inc.
10977 Granada Lane, suite 103
Overland Park, Kansas 66211

Dear Mr. Wolcott:

We have received your draft report on the State of Montana Prescription Drug Claim Audit for the period of July 1, 1997 through June 30, 1998, and we provide the following responses to your audit findings and recommendations.

RECOMMENDATION 1 – AWP Pricing: We recommend that ESI either process Buttrey mail order claims on a basis consistent with how other claims are processed (paid based on the AWP in effect at the time the prescription is filled) or amend the agreements to provide for a payment method that agrees with their practice (paid based on the AWP in effect on the date ESI is billed by Buttrey.

RESPONSE: We concur with the recommendation that claims payment processes be consistent and agree with Express Scripts proposed correction.

RECOMMENDATIONS 2-5 – Copayment and Deductible: We recommend the following:

- ESI should immediately revise their claim processing software so that it is capable of processing plan claims as agreed upon with the State.
- ESI should immediately begin a program of manual review of all State claims to assure that out-of-pocket limits are not exceeded. This manual review should continue until the software revision is proved effective.
- ESI should immediately review all State claim history to identify individuals and families that have been charged more than the contractual copay and deductible. Refund checks should be sent to each over charged person
- ESI should provide a monthly progress report to the State until these steps have been completed.

RESPONSE: We concur with the recommendation and Express Scripts proposal for revising its system and reimbursing members who have been charged more than the contractual copay.

RECOMMENDATION 6 – Applies to University System.

RECOMMENDATION 7 – State Copay Percentage: We recommend that ESI produce their supporting documentation for the use of a 25% copay. If none exists, ESI should refund overpayments to the State.

RESPONSE: ESI's response indicates that the prescription in question was not a prescription drug but a diabetic supply and the 25% copay is the copay applied for such supplies under the medical plan. While ESI is correct that 25% is the copay applied under the medical plan, we note that diabetic supplies are subject to the standard Rx copays of $30 or $10 when processed through the mail order. We will review this issue and instruct ESI on a copay for diabetic supplies.

RECOMMENDATION 8 – Prior Approval Drugs: We make the following recommendations:

- ESI should research all claims history to identify all drugs subject to prior approval. When such approval was not obtained., each plan sponsor should be reimbursed for the sum of the overpayments.
- .ESI and each plan sponsor should review the prior approval provision and agree to the drugs that should be subject to prior approval.
- ESI should demonstrate that the prior approval edits are functioning properly.
- ESI should provide monthly reports of progress until the project is completed.

RESPONSE: ESI, in their response, indicate that prior authorizations were on record for numerous other similar birth control scripts for this same individual but not for the particular script sampled. They also indicated that the system requires a prior authorization to process, so it is not a systems problem. The problem is most likely an inadvertent deletion of the prior authorization. It has been our experience that Rxs requiring prior authorization are defined and do not process without prior authorization.

RECOMMENDATION 9 – Paper Claims: We recommend the following:

- ESI should begin processing paper claims in compliance with the agreements.
- ESI should research the claim history for all plan sponsors to identify over paid paper claims. Refunds should be issued to each sponsor.
- ESI should provide monthly status reports until the refunds have been issued.

RESPONSE: We concur with this recommendation.

RECOMMENDATION 10: – COB Claims: We suggest that all four sponsors review this plan provision. If they determine that the COB provision should be utilized, periodic data should be provided to ESI so that savings can be obtained.

RESPONSE: The State Plan does request member confirmation of the prescription drug COB status reported on their confirmation statement each year. Any reported changes are entered into the eligibility information provided to ESI. We will evaluate obtaining COB information from the medical claims processor and conducting a one-time member inquiry of whether other coverage includes prescription drug coverage, and forward that information to ESI.

RECOMMENDATION 11 – Participant Confirmations: We suggest the following procedures are employed in future years:

- Confirmations should be requested on plan sponsor letterhead to emphasize the official nature of the correspondence.
- Participants who do not respond to the confirmation request should be notified that access to the prescription drug program will be restricted until the requested information is provided.

RESPONSE: We would be happy to provide a generic cover letter indicating that the auditor has been duly authorized to gather information for an audit and stressing the importance of the audit. We do not agree with specifying personal prescription drug information on employer letterhead. We will take the second recommendation under advisement.

RECOMMENDATION 12 – Duplicate claim overpayment: Applies to the University system.

RECOMMENDATION 13 – Date Stamping: Internal to ESI.

RECOMMENDATION 14 – Drug Utilization Review: We recommend that ESI provide a detailed report of DUR activity during the audit period to support their statement that the DUR system is effective. Illustrations of each of the contractual edits should be included in the report.

RESPONSE: We concur.

RECOMMENDATION 15 – Other: We suggest each sponsor request that ESI provide reports on a quarterly basis regarding their guaranteed performance and the results of pharmacy audits in Montana.

RESPONSE: We concur with this recommendation.

Thank you for the opportunity to respond.

Sincerely,

Joyce Brown, Chief
Employee Benefits Bureau

MONTANA UNIVERSITY SYSTEM
OFFICE OF COMMISSIONER OF HIGHER EDUCATION

2500 BROADWAY PO BOX 203101 · HELENA, MONTANA 59620-3101 (406)444-6570 FAX (406)444-1469

November 19, 1998

EXHIBIT F

Ray Wolcott, Jr. C.F.E.
Wolcott & Associates, Inc
Suite 103
10977 Granada Lane
Overland Park, Kansas 66211

Dear Mr. Wolcott:

Thank you for the opportunity to respond to your claims audit of the Express Scripts administered pharmacy plan for Montana University System employees. In general I agree with your recommendations concerning Express Scripts, however I have not had the opportunity to see the Express Scripts response to your findings. There are several recommendations that suggest actions on the part of the University System. I will respond more specifically to those recommendations.

COB CLAIMS

You suggest that we review the Coordination of Benefits provision of our agreement and if we determine that the COB provision should be utilized, we provide ESI with COB data. We concur with this recommendation and will discuss this with both ESI and Blue Cross Blue Shield of Montana (BCBSMT). BCBSMT administers the COB provisions of our health plan.

PARTICIPANT CONFIRMATIONS

You suggest that plan confirmations should be requested on plan sponsor letterhead and that we should notify nonrespondants that access to the prescription drug program will be restricted until the requested information is provided. We partially concur with this recommendation. We will provide the auditor with a cover letter on letterhead that can be sent with the auditor's request for information. Some of our plan participants are concerned about OCHE access to individual medical and prescription data. We believe sending letters with specific prescription data on our letterhead would fuel those concerns.

For similar reasons, we are not going to restrict prescription plan access to those members who do not respond to the auditor's sample questionnaire.

DUPLICATAE CLAIM OVERPAYMENT

ESI has processed a refund for the duplicate invoice that was paid by the MUS.

The Montana University System will follow up with Express Scripts on the other audit recommendations that indicated problems with their plan administration, especially those which could lead to a recovery of funds from ESI and those which could lead to better service to plan members.

Sincerely,

Glen D. Leavitt
Interim Director of Benefits